TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13750 **CERTIFICATE OF DEATH** 13754

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 1 HR
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON RD #2 ELK FOREST
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRIEDA — Middle ACTON — Last

4. DATE OF DEATH: Month OCTOBER — Day 26 — Year 1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
FEMALE	WHITE		FEB. 10, 1891	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE	AT HOME	PHILA PA	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GUSTAVUS HORNBERGER	ANNA HUME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
No		HOWARD E. COSGROVE — RD #2 ELKTON

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): ARTERIOSCLEROTIC HEART DISEASE — 2 HRS.
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from NOVEMBER 1962 to OCT 26, 1967 that (I) (we) last saw the deceased alive on OCT 26 1967 and that death occurred at 9:12 M, from causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
J. Randall Ross					10/26/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
J. RANDALL ROSS, M.D.	ELKTON, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10/30/67	FERNWOOD CEMETERY	FERNWOOD PA

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
PIPPIN F.H.	ELKTON, Md	OCT 30 1967	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13755

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 85 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Queen Anne's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sudlersville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PEARSON — Middle B. — Last ADAMS JR.

4. DATE OF DEATH: Month October — Day 18 — Year 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-4-24
9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Mechanic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Sutton, West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Pearson Adams (D)
14. MOTHER'S MAIDEN NAME: Bessie Jane Mealey (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW II
16. SOCIAL SECURITY NO. 234-30-8738
17. INFORMANT (Address): VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Meningitis, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 1½ MO.
DUE TO
(b): Septicemia
DUE TO
(c): Abscesses of Lungs, Multiple
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from July 25, 1967, to Oct. 18, 1967 that ☒ I last saw the deceased alive on ☒ and that death occurred at 9:30 am, from causes and on the date stated above.

22a. SIGNATURE: a. L. Mooney M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: Oct.18,1967
22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D. Path.
22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct.22,1967
23c. NAME OF CEMETERY OR CREMATORY: Sutton Cemetery
23d. LOCATION (City or Town) (County) (State): Sutton, W.Va.

24. FUNERAL DIRECTOR: Edward Fellows Funeral Home
ADDRESS: Edward Fellows Funeral Home, Millington, Md.
25a. REC'D BY REGISTRAR DATE: OCT 20 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13752 13756

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 5 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: R.D. # 3 Box 411
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Elizabeth — Last: Adkins

4. DATE OF DEATH: Month: October — Day: 25 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Jan. 24, 1872

9. AGE (In years last birthday): 95 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Adkins

14. MOTHER'S MAIDEN NAME: S. Elizabeth Ballinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mr. Jess Adkins, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia & Anemia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Anemia & Arteriosclerosis — 3-4 weeks
DUE TO (c): Generalized Arteriosclerosis — 1-2 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture, left Hip. — **19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☒ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Lost Balance + fell to floor 8/15/67, 10:00 A.M. - at home

20c. TIME OF INJURY Month, Day, Year: Hour a.m. 10:00 a.m. 8/15/1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME

20f. (City or town) ELKTON (County) CECIL (State) MD.

21. I certify that (I) (this hospital) attended the deceased from 8/24, 1967, to 10/25, 1967, that (I) (we) last saw the deceased alive on 10/25 1967, and that death occurred at 8:00 A.M. from causes and on the date stated above.

22a. SIGNATURE: Rolando A. Najera — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10/26/67

22c. PHYSICIAN'S NAME (Type): Rolando A. Najera

22d. ADDRESS: 105 E. Main St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/28/67

23c. NAME OF CEMETERY OR CREMATORY: Breen Cemetery

23d. LOCATION (City or Town) (County) (State): Hinton, West Virginia

24. FUNERAL DIRECTOR: Ralph E. Hicks

ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: OCT 30 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13753 **CERTIFICATE OF DEATH** 13757

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton Rural
c. LENGTH OF STAY IN This: 5weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Elkton 07-1
d. STREET ADDRESS: Elkton R.D. # 5 Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Howard Middle William Last Anderson
4. DATE OF DEATH: Month October Day 7 Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ## NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-19-1903
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Fibre Mill
11. BIRTHPLACE (County & State, or foreign country): Cecil Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Harry Anderson
14. MOTHER'S MAIDEN NAME: Lydia Whiteman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO.: 216-28-5918
17. INFORMANT Address: Mrs Lillie Anderson Elkton # 5 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): SEPTECEMIA & ASHD — INTERVAL BETWEEN ONSET AND DEATH
331x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): PNEUMONITIS & LEG ULCER
DUE TO (c): CEREBRAL VASCULAR ACCIDENT

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/3, 19 67 to 10/7 19 67, that (I) (we) last saw the deceased alive on 10/7 19 67 and that death occurred at 2 M, from causes and on the date stated above.

22a. SIGNATURE: I. R. Ross M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): I. R. ROSS, M.D.
22d. ADDRESS: MEDICAL PARK, ELKTON, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-11-1967
23c. NAME OF CEMETERY OR CREMATORY: Oxford Cemetery
23d. LOCATION (City or Town) (County) (State): Oxford, Chester Co Pa

24. FUNERAL DIRECTOR: William J. Johnston — ADDRESS: Oxford, Pa.
25a. REC'D BY REGISTRAR DATE: OCT 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13754

CERTIFICATE OF DEATH

13758

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Earleville
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Earleville
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle — Last BIDDLE

4. DATE OF DEATH: Month October — Day 8, — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February, 23, 1895

9. AGE (In years last birthday): 72 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming.

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): Delaware.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Henry Biddle

14. MOTHER'S MAIDEN NAME: Mary E. Kelley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No.
   (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Anna Biddle, Earleville, Md. 21919

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 11 ho

3318

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

Diabetes mellitus mild, Arteriosclerotic Heart Disease.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 1967, to 8 Oct, 1967, that (I) (we) last saw the deceased alive on 8 Oct 1967, and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9 Oct 67

22c. PHYSICIAN'S NAME (Type): Wallace Obenshain. M.D.

22d. ADDRESS: Cecilton, Md. 21913

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct. 10, 1967

23c. NAME OF CEMETERY OR CREMATORY: Johntown Cemetery

23d. LOCATION (City, town or county) (State): Earleville, Md.

24. FUNERAL DIRECTOR — ADDRESS: Edward Fellows & Son, Millington, Md. 21651

25a. REC'D BY REGISTRAR DATE: OCT 11 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13755

CERTIFICATE OF DEATH

13759

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1½ mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital of Cecil Co.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS: 102 E. Cecil Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Christina — Middle: Miller — Last: Biscoe

4. DATE OF DEATH: Month: Oct. — Day: 27 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/13/13

9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: William Miller

14. MOTHER'S MAIDEN NAME: Agnes Patterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 212-18-1219

17. INFORMANT: Jesse Biscoe — Address: 102 E. Main St. North East, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Adenocarcinoma of ovary — INTERVAL BETWEEN ONSET AND DEATH: 4 mos.
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/15, 1967, to 10/27, 1967, that (I) (we) last saw the deceased alive on 10/27 1967, and that death occurred at 7:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Edgar E. Folkem M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 10/28/67

22c. PHYSICIAN'S NAME (Type): Edgar E. Folkem, M.D.

22d. ADDRESS: Union Hospital, Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-30-67

23c. NAME OF CEMETERY OR CREMATORY: North East Meth.

23d. LOCATION (City or Town) (County) (State): North East Cecil Md.

24. FUNERAL DIRECTOR: Paul Crouch Grant Funeral Home — ADDRESS: Box 22 North East Md.

25a. REC'D BY REGISTRAR DATE: OCT 31 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13755

CERTIFICATE OF DEATH

13260

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 405 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 944 Virginia Ave SW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORMAN — Middle G. — Last BOUTWELL
4. DATE OF DEATH: Month October — Day 29 — Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 2, 1891
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Auto repair
11. BIRTHPLACE (County & State, or foreign country): ~~Talbot~~ Georgia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO: 212-16-0361
17. INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Bronchopneumonia
4 Y I X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic heart disease
Chronic brain syndrome assoc/w cerebral arteriosclerosis.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I/this hospital) attended the deceased from Sept. 19, 19 66, to Oct. 29, 19 67, I ~~saw the body~~ and that death occurred at 2:25 p.m., from causes and on the date stated above.

22a. SIGNATURE: S. Goldgraben
M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 10-30-67
22c. PHYSICIAN'S NAME (Type): S. GOLDGRABEN, M.D.
22d. ADDRESS: VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 2-1967
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Suitland, Md

24. FUNERAL DIRECTOR: Simmons Bros. — ADDRESS: Wash., DC
Simmons Funeral Home, 1661 Goodhope Road,
25a. REC'D BY REGISTRAR DATE: NOV 1 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13757 — 13761

PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 22 mos 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
d. STREET ADDRESS: VA Hospital
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
MICHAEL		BREEN	October	1	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Male	White		5- -86	81 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Civil service	Same	Ireland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Michael Breen	Catherine Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes WW I	578-22-8226	VA Hospital records, Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 4-7 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Arteriosclerotic Heart Disease with Myocardial fibrosis — Years
DUE TO (c): Arteriosclerosis, generalized — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from Dec. 17, 1965 to Oct. 1, 1967, [illegible] and that death occurred at 8:20 am, from causes and on the date stated above.

22a. SIGNATURE	M.D	ATTENDING PHYS ☐	MED DIRECTOR ☐	STAFF PHYS ☒	22b. DATE SIGNED
A. L. Mooney					10-2-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
A. L. MOONEY, M.D.	VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/5/1967	HOLDEN PARK NAT. CEM.	BALTIMORE Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Pennington & Son Funeral Home, Havre de Grace, Maryland	OCT 9 1967	[illegible] Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1B (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13759

CERTIFICATE OF DEATH

13762

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Frenchtown Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Rural Port Deposit
d. STREET ADDRESS: Rt. 222
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: G. — Last: Clayton

4. DATE OF DEATH: Month: Oct. — Day: 9, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Cau.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 29, 1883

9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William LaMar

14. MOTHER'S MAIDEN NAME: Mary Ann Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): -----

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Margaret Cully, Perryville, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Cardiac failure
DUE TO (b): Myocardial infarction
DUE TO (c): Arteriosclerosis
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH
1/2 hour
2 month
2 yrs -

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Aug 30, 1967 to Oct 9, 1967, that (I) (we) last saw the deceased alive on Oct 9 1967, and that death occurred at 11 P. M, from causes and on the date stated above.

22a. SIGNATURE: Clarence I. Benson M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Oct 10-67

22c. PHYSICIAN'S NAME (Type): Clarence I. Benson M. D.

22d. ADDRESS: Port Deposit, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct. 12, 1967

23c. NAME OF CEMETERY OR CREMATORY: Charlestown Cemetery

23d. LOCATION (City or Town) (County) (State): Charlestown, Maryland.

24. FUNERAL DIRECTOR: Lee H. Patterson & Son
ADDRESS: Perryville, Md.

25a. RECD BY REGISTRAR DATE: OCT 17 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13759

CERTIFICATE OF DEATH

13763

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2d.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Union Hosp. of Cecil Co.

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS: 215. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: Rebecca — Middle: Hyland — Last: Davis

4. DATE OF DEATH: Month: Oct. — Day: 11 — Year: 1967

5 SEX: F

6 COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8 DATE OF BIRTH: 8/18/83

9 AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Cecil Co., Md.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joshua H. Hyland

14. MOTHER'S MAIDEN NAME: Helen Killingsworth

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 220-54-6162

17 INFORMANT Address: Hospital records, Union Hosp.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Atherosclerosis of cerebral arteries — 36 hours
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct. 10, 1967, to Oct. 11, 1967 that (I) (we) last saw the deceased alive on Oct. 11 1967, and that death occurred at 9:30 PM, from causes and on the date stated above.

22a. SIGNATURE: Edgar E. Folk III M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Oct. 12, 1967

22c. PHYSICIAN'S NAME (Type): Edgar E. Folk III, M.D.

22d ADDRESS: Union Hospital, Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-14-67

23c. NAME OF CEMETERY OR CREMATORY: North East meth.

23d. LOCATION (City or Town) (County) (State): North East Cecil Md.

24. FUNERAL DIRECTOR: Paul R. Crouch — ADDRESS: Box 22 North East Md.
Grout Funeral Home

25a. RECD BY REGISTRAR DATE: OCT 16 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

13760

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13764

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: DISTRICT OF COLUMBIA — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2149 N St N W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thurman — Middle — Last: FINCH
4. DATE OF DEATH: Month: October — Day: 19 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1 16 16
9. AGE (In years last birthday): 51 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tire changer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Wilson, North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Finch (D)
14. MOTHER'S MAIDEN NAME: Fanny (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO: 231 12 26 91
17. INFORMANT — Address: VA Hospital Records - Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of stomach w/liver metastasis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9 29 67, 19__ to 10 19 67, 19__, that ~~I (this hospital) last saw the deceased on~~, and that death occurred at 8:15 P.M., from causes and on the date stated above.

22a. SIGNATURE: Joaquin R. Garcia M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 10-20-67
22c. PHYSICIAN'S NAME (Type): J. R. GARCIA, M.D.
22d. ADDRESS: VA Hospital - Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10-24-67
23c. NAME OF CEMETERY OR CREMATORY: HARMONY MEM. PARK
23d. LOCATION (City or Town) (County) (State): HIGHLAND PARK, P.G. Md.

24. FUNERAL DIRECTOR: Robert G. McGuire — ADDRESS: Robert G. McGuire 1820-9-Wnd
McGuire Funeral Home, Washington, DC

25a. REC'D BY REGISTRAR DATE: OCT 23 1967
25b. REGISTRAR'S SIGNATURE: Orlando Custis

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13761 — 13765

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1st and 2nd should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Virginia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 3453 North Emerson Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JAMES — Middle FRANCIS — Last FLYNN

4. DATE OF DEATH: Month October — Day 2 — Year 1967

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-1-34
9. AGE (In years last birthday): 32 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Programmer
10b KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): New York City, N.Y.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Flynn (D)
14. MOTHER'S MAIDEN NAME: Margaret O'Neill (L)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes 7-15-56/3-9-63
16. SOCIAL SECURITY NO: 058-28-2760
17 INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Hepatic insufficiency with massive ascites — INTERVAL BETWEEN ONSET AND DEATH: weeks
DUE TO: and jaundice
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cirrhosis of liver, Laennec's — years
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from Sept. 15, 1967, to Oct. 2, 1967 and that death occurred at 3:20 am from causes and on the date stated above.

22a SIGNATURE: A. L. Mooney — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: 10-2-67
22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D.
22d. ADDRESS: VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10/5/67
23c NAME OF CEMETERY OR CREMATORY: Culpeper Nat. Cem.
23d LOCATION (City or Town) (County) (State): Culpeper Culpeper Va.

24. FUNERAL DIRECTOR: Fitzgerald Funeral Home, 3245 Wilson Blvd., ADDRESS Arlington, VA.
25a REC'D BY REGISTRAR DATE: OCT 4 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13762 — 15972

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Devin Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: R. — Last: George

4. DATE OF DEATH: Month: October — Day: 30, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Cau.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 26, 1883

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (County & State, or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Thompson

14. MOTHER'S MAIDEN NAME: Annie Bouchelle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: L. Osmond George, Perryville, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 6 Months pneumonia
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Severe generalized rheumatoid arthritis - several years

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-23, 1965, to 10-30, 1967, that (I) (we) last saw the deceased alive on 10-30 1967, and that death occurred at 5 P M, from the causes and on the date stated above.

22a. SIGNATURE: S. Ralph Andrews Jr M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/30/67

22c. PHYSICIAN'S NAME (Type): S. RALPH ANDREWS JR MD
22d. ADDRESS: ELKTON, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 2, 1967
23c. NAME OF CEMETERY OR CREMATORY: Hopewell Cemetery
23d. LOCATION (City, town or county) (State): Port Deposit, Maryland.

24. FUNERAL DIRECTOR: Lee A. Patterson & Son
ADDRESS: Perryville, Maryland.
25a. REC'D BY REGISTRAR DATE: NOV 8 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1 t

13763

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13766

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 142 W. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DANIEL — Middle: W. — Last: HENRY

4. DATE OF DEATH: Month: October — Day: 31 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-11-88

9. AGE (In years last birthday): 79 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Court stenographer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Elkton, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Henry (D)

14. MOTHER'S MAIDEN NAME: Mary Johnson (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 216-01-8026

17. INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
331X
IMMEDIATE CAUSE (a): Cerebral hemorrhage secondary to arteriosclerosis
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from Oct. 16, 1967, to Oct. 31, 1967, [illegible] and that death occurred at 12:25 pm, from causes and on the date stated above

22a. SIGNATURE: Edgar E. Folk III — M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 10/31/67

22c. PHYSICIAN'S NAME (Type): EDGAR E. FOLK III

22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/3/67

23c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery

23d. LOCATION (City or Town) (County) (State): Elkton, Md.

24. FUNERAL DIRECTOR: Ralph E. Hicks — ADDRESS: Hicks Funeral Home, Elkton, Md.

25a. REC'D BY REG STRAR DATE: NOV 6 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13764 — 13767

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Port Deposit
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 3 Mill Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Port Deposit
d. STREET ADDRESS: 3 Mill Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Pearl — Middle: M. — Last: Honesty
4. DATE OF DEATH: Month: Oct. — Day: 3 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 26, 1901
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (County & State, or foreign country): Port Deposit, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Walter Henry
14. MOTHER'S MAIDEN NAME: Mary Gordy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 219-10-0779
17. INFORMANT: Mr. William H. Honesty Sr. — Address: 3 Mill Street Port Deposit, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebrovas cular accident
331X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral arteriosclerosis
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 1 day; 13 yrs. (illegible)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 1966 to 10-3-1967, that (I) (we) last saw the deceased alive on 10-1-1967, and that death occurred at 11 A M, from the causes and on the date stated above.

22a. SIGNATURE: Neil R Taylor M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-3-67
22c. PHYSICIAN'S NAME (Type): Neil R Taylor Jr M D
22d. ADDRESS: Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 8, 1967
23c. NAME OF CEMETERY OR CREMATORY: Cokesbury Cemetery
23d. LOCATION (City, town or county) (State): Cokesbury - Cecil Co, Md.

24. FUNERAL DIRECTOR: Otelia J. Bullock — ADDRESS: Havre de Grace Md.
25a. REC'D BY REGISTRAR DATE: OCT 5 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4) 20M 1/65.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13765 — 13768

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: R.D. 1 Box 274
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Viola — Middle: — Last: Howell

4. DATE OF DEATH: Month: October — Day: 22, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 12, 1895

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Senate Justice

14. MOTHER'S MAIDEN NAME: Lilly Belle Justice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 234-40-7927

17. INFORMANT Address: Mrs. Inez G. Brooks, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIO-VASCULAR FAILURE — INTERVAL BETWEEN ONSET AND DEATH: one hour
DUE TO (b): Cancer of the Pancreas (TERMINAL) — over 2 yrs
DUE TO (c): Metastasis of liver and aortic lymph Nodes — years
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last: 157x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): G.A.S. C/ A.S.C.V.D.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 2-15-65, to 10-22-67, that (I) (~~we~~) last saw the deceased alive on 10-22-67, and that death occurred at ____ M, from causes and on the date stated above

22a. SIGNATURE: Luis M. Cuza M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10-23-67

22c. PHYSICIAN'S NAME (Type): LUIS M. CUZA, M.D.
22d. ADDRESS: 322 E. Cecil Avenue, North East, Md. 21901

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/26/67

23c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery

23d. LOCATION (City or Town) (County) (State): Elkton, Md.

24. FUNERAL DIRECTOR: Ralph E. Hicks
ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: OCT 30 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

13766 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13769

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 3d.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Delaware — b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
d. STREET ADDRESS: 24 Center St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Josephine — Middle: L. — Last: Lacey
4. DATE OF DEATH: Month: October — Day: 21 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 22, 1885
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: August Hertzer
14. MOTHER'S MAIDEN NAME: Katherine Sherman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Edmund Lacey — Address: Newark, Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis of cerebral arteries
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 18, 1967, to Oct. 21, 1967, that (I) (we) last saw the deceased alive on Oct. 21 1967, and that death occurred at 1 05 P.M., from causes and on the date stated above

22a. SIGNATURE: Edgar E. Folk III — M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: Oct. 21, 1967
22c. PHYSICIAN'S NAME (Type): Edgar E. Folk III, M.D.
22d. ADDRESS: Union Hosp., Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/23/67
23c. NAME OF CEMETERY OR CREMATORY: Restland Cem.
23d. LOCATION (City or Town) (County) (State): Hanover, New Jersey

24. FUNERAL DIRECTOR: R. T. Jones — ADDRESS: Newark, Delaware
25a. REC'D BY REGISTRAR DATE: OCT 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

13767
Items 18-21 Film 396
1-8-68 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13776

1 PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2HRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Delaware
b. COUNTY: Newcastle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newcastle
d. STREET ADDRESS: 209 W. Monroe Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JOHN — Middle HOWARD — Last LeGates
4 DATE OF DEATH: Month October — Day 9 — Year 19 67

5 SEX	6 COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Male	White	WIDOWED ☒	FEB. 26, 1900	67 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TAX ACCT	ACCOUNTING	DEL.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN R. LEGATES	NAOMI COLLISON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	—	CHARLES H. LEGATES NEW CASTLE DEL.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Craniocerebral and thoracic injuries
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
S16.4
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)				
	Subject driver in auto-auto collision				
20c TIME OF INJURY Month, Day, Year; Hour o.m.	**20d INJURY OCCURRED**	**20e PLACE OF INJURY** (Home, farm, factory, street, office bldg. etc.)	**20f** (City or town)	(County)	(State)
12:03 PM 10-9 1967	While at work ☐ Not While at work ☒	Street	Elkton	Cecil	Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Edward F. Wilson, M.D.
Address (Street, city, town, or county):
22. DATE SIGNED: October 9, 1967

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	10/12/67	GRACELAWN	NEWCASTLE CO. DEL.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
PIPPIN FUNERAL HOME	ELKTON Md.	OCT 13 1967	Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM2. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13763

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13772

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 188 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: Box 202
e. RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OTIS — Middle: Junior — Last: LUCHINI

4. DATE OF DEATH: Month: October — Day: 2 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-17-19

9. AGE (In years last birthday): 48 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Cable Mfr

11. BIRTHPLACE (State or foreign country): Bristol, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ferdinand Luchini

14. MOTHER'S MAIDEN NAME: Cora Lee Shaffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW II

16. SOCIAL SECURITY NO: 229-05-8093

17. INFORMANT — Address: VA HOSPITAL RECORDS, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia by drowning
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Depressive reaction, suicidal

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH: death

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Apparently jumped off fishing pier at VAH, P. P. Md.

20c. TIME OF INJURY Hour: 2:30 am/pm — Month, Day, Year: 10/2 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Susquehanna Flats

20f. (City or town) (County) (State): Perry Point Cecil Maryland

21. I certify that I took charge of the remains described above held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John M Byers, M D Acting

EXAMINER'S NAME (Type): John M. Byers, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street city, town, or county): Elkton, Maryland

22. DATE SIGNED: 10-2-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/5/67

23c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Memorial Park

23d. LOCATION (City or Town) (County) (State): Elkton, Md.

24. FUNERAL DIRECTOR: Ralph E. Hicks — ADDRESS: Hicks Funeral Home, Elkton, Maryland

25a. REC'D BY REGISTRAR — DATE: OCT 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13763 13763

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CECIL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): AIKEN
c. LENGTH OF STAY IN 1b: 10 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): — RD#1 Box 45

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): AIKEN
d. STREET ADDRESS: — RD#1 Box 45
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WALTER Middle: LEE Last: MARTIN

4. DATE OF DEATH: Month: OCT. Day: 21 Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: JAN. 26, 1897

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (County & State, or foreign country): MD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WALTER L. MARTIN SR.

14. MOTHER'S MAIDEN NAME: ANNA V. MARTIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WORLD WAR #1

16. SOCIAL SECURITY NO.: 213-44-8923

17. INFORMANT: MARIAN L. MARTIN, Address: AIKEN, Cecil Co. MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Emphysema

DUE TO (b): Pulmonary edema

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): A.S.C.V.D

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/9 19 67 to 10/20 19 67 that (I) (we) last saw the deceased alive on 10/20 19 67, and that death occurred at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John Yun M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): JOHN D. YUN

22d. ADDRESS: HAVRE DE GRACE MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Oct 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: ST. MARK'S Cem

23d. LOCATION (City, town or county): Cecil Co. (State): MD.

24 FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR: OCT 25 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

VR A1S (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13770

CERTIFICATE OF DEATH

13774

1 PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 11 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHERRY HILL
d. STREET ADDRESS: NONE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELSIE — Middle: Mc — Last: BOISE

4. DATE OF DEATH: Month: 10 — Day: 18 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-2-89

9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRACTICAL NURSE

10b. KIND OF BUSINESS OR INDUSTRY: NURSING

11. BIRTHPLACE (County & State, or foreign country): WILMINGTON, DEL

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MICHAEL McCORMICK

14. MOTHER'S MAIDEN NAME: MARY BAIL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 147-12-7077

17. INFORMANT: ELSIE E. HOLMES — Address: ELKTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): ACUTE CEREBRAL EDEMA. — Interval between onset and death: Hours?
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): CEREBRAL ANOXIA — Interval: Hours
DUE TO
(c): PULMONARY EMPHYSEMA BRONC[illegible] — Interval: Years?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): HAHD

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Apr [illegible], 19[illegible], to [illegible], 1967, that (I) (we) last saw the deceased alive on [illegible] 1967, and that death occurred at [illegible] A.M., from causes and on the date stated above.

22a. SIGNATURE, M.D.: [signature] — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10/20/67

22c. PHYSICIAN'S NAME (Type): PETER STAVRAKIS

22d. ADDRESS: ELKTON MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 10-21-67

23c. NAME OF CEMETERY OR CREMATORY: SILVERBROOK

23d. LOCATION (City or Town) (County) (State): WILMINGTON NEW CASTLE DEL

24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME — ADDRESS: Robert Paul ELKTON, MD.

25a. REC'D BY REGISTRAR DATE: OCT 23 1967

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13771 — 13775

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East — Rural
d. STREET ADDRESS: R.F.D. # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carroll — Middle: Eston — Last: Pyle
4. DATE OF DEATH: Month: Oct. — Day: 18 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 11 1921
9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: Scott Const. Co.
11. BIRTHPLACE (County & State, or foreign country): Cecil Co. Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Casper Pyle
14. MOTHER'S MAIDEN NAME: Ida Rock
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 216-16-3715
17. INFORMANT: Mrs. C. Easton Pyle — Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO (b): Hypertensive Cardio-vascular Disease — 3 mo
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): —
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —
20f. (City or town) — (County) — (State)

21. I certify that (I) (this hospital) attended the deceased from 1 Aug, 1967, to 18 Oct, 1967, that (I) (we) last saw the deceased alive on 25 Aug 1967, and that death occurred at 6A.M, from causes and on the date stated above.

22a. SIGNATURE: Klaus H. Huebner — M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/18/67
22c. PHYSICIAN'S NAME (Type): KLAUS H. HUEBNER M.D
22d. ADDRESS: NORTH EAST, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-21-67
23c. NAME OF CEMETERY OR CREMATORY: Rose Bank Cem.
23d. LOCATION (City or Town) (County) (State): Calvert Cecil Md.
24. FUNERAL DIRECTOR: Vernon E. Mullen — ADDRESS: Rising Sun, Md
25a. RECD. BY REGISTRAR DATE: OCT 20 1967
25b. REGISTRAR'S SIGNATURE: Winston Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13772

CERTIFICATE OF DEATH

13776

1 PLACE OF DEATH
a. COUNTY Cecil — MARYLAND

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1 month
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Elkton

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital
d. STREET ADDRESS: R.D. 2
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JENNIE Middle I. Last RAHELICH
4. DATE OF DEATH: Month Oct. Day 30 Year 19 67

5 SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 7, 1890
9 AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Mike Perovic
14. MOTHER'S MAIDEN NAME: Anntonly Stepavic

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Maryan Rahelich Address: Box 221 Mountainville, N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.
DUE TO (b): Generalized Atherosclerosis — 8 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pyelonephritis. Diabetes Mellitus
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): —
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): —
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. — 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 30 Sept, 1967, to 30 Oct, 1962, that (I) (we) last saw the deceased alive on 30 Oct 1967, and that death occurred at 2:15 A.M., from causes and on the date stated above

22a SIGNATURE: Klaus H. Huebner — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10/30/67
22c. PHYSICIAN'S NAME (Type): KLAUS H. HUEBNER
22d. ADDRESS: NORTH EAST, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 11-2-67
23c NAME OF CEMETERY OR CREMATORY: North East Methodist
23d LOCATION (City or Town) (County) (State): North East Cecil Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — Paul S. Crouch
ADDRESS: Box 22 North East, Md.
25a. REC'D BY REGISTRAR DATE: NOV 1 1967
25b REGISTRAR'S SIGNATURE: Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13773 — 13773

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c LENGTH OF STAY IN 1b: 4 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Penna. b. COUNTY: York
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delta
d STREET ADDRESS: RD # 1
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Frederick Middle: C. Last: SMITH
4 DATE OF DEATH: Month: October Day: 19, Year: 1967

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 8 12 19
9 AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Welder
10b. KIND OF BUSINESS OR INDUSTRY: Shipbuilding
11 BIRTHPLACE (County & State or foreign country): Chester, Pa.
12 CITIZEN OF WHAT COUNTRY? U.A.A.

13 FATHER'S NAME: Clinton (deceased) Smith
14. MOTHER'S MAIDEN NAME: Ruth Doyle

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO: 205 05 90 69
17 INFORMANT Address: VA Hospital Records - Perry Point, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4-7 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Acute cerebral hemorrhage — 7-10 days
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that ☒ (this hospital) attended the deceased from 10 15 67, 19__ to 10 19 67 19__, ~~saw the deceased alive on~~ ~~19~~, and that death occurred at 4:40 PM, from causes and on the date stated above.

22a SIGNATURE: Joaquin R. Garcia M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: 10 20 67
22c PHYSICIAN'S NAME (Type): J. R. GARCIA, M.D.
22d ADDRESS: VA Hospital - Perry Point, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Oct.22,1967
23c NAME OF CEMETERY OR CREMATORY: Mt. Nebo
23d. LOCATION (City or Town) (County) (State): Delta, York Co., Pa.

24 FUNERAL DIRECTOR: John H. Harkins ADDRESS: HARKINS FUNERAL HOME - Delta Penna.
25a REC'D BY REGISTRAR DATE: OCT 24 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13774 — Reg. Dist. No. 13778

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Warwick
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Warwick
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: R. — Last: Smith

4. DATE OF DEATH: Month: Oct — Day: 8 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 25, 1903

9. AGE (In years last birthday): 64 yr yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Prop. of Traven

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Evans R. Smith

14. MOTHER'S MAIDEN NAME: Emily Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W. I

16. SOCIAL SECURITY NO.: 173-07-0921

17. INFORMANT: Mrs. Frances Smith — Address: Warwick, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma
DUE TO
(b): primary in larynx
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/18, 1964, to 10/8, 1967, that I last saw the deceased alive on Oct. 8, 1967, and that death occurred at 9:15a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Allan R. Cruchley M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 10/9/67

PHYSICIAN'S NAME (Type): Allan R. Cruchley, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/12/67
22c. NAME OF CEMETERY OR CREMATORY: Greenmount Cem.
22d. LOCATION (City, town, or county) (State): West Chester Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Lester Daniels — ADDRESS: Middletown, Del.

24a. REC'D BY REGISTRAR DATE: OCT 13 1967 — 24b. REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13775

CERTIFICATE OF DEATH

13779

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital, Perry Point, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 6912 Greenvale Street, N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: W. — Last: Stant

4. DATE OF DEATH: Month: October — Day: 21 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 12, 1875

9. AGE (In years last birthday): 92 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Stant

14. MOTHER'S MAIDEN NAME: Jane Russell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): SAW

16. SOCIAL SECURITY NO.: 579 60 00 30

17. INFORMANT: VA Records — Address: VAH, Perry Point, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY-
IMMEDIATE CAUSE (a): Branchopneumonia of both lungs
491X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): aspiration Type
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 10-15 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-28, 1967, to 10-21, 1967, [illegible] and that death occurred at 12:45 PM, from causes and on the date stated above.

22a. SIGNATURE: Gladys Ocejo — M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10-22-67

22c. PHYSICIAN'S NAME (Type): G. OCEJO, M.D.

22d. ADDRESS: VA Hospital - Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 10-23-67

23c. NAME OF CEMETERY OR CREMATORY: Congressional Cemetery

23d. LOCATION (City or Town) (County) (State): Washington D.C.

24. FUNERAL DIRECTOR: Humphrey Funeral Home

ADDRESS: Wash DC

25a. REC'D BY REGISTRAR DATE: OCT 24 1967

25b. REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13775 — 13746

1 PLACE OF DEATH
a COUNTY: CECIL — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL ELKTON #2
c LENGTH OF STAY IN 1b: 6 YEARS
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NONE

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: MD — b COUNTY: CECIL
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL ~~CHESAPEAKE CITY~~ ELKTON ROAD 2
d STREET ADDRESS: NONE
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First CHARLES — Middle FRANKLIN — Last WADKINS

4 DATE OF DEATH: Month OCTOBER — Day 7 — Year 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 6-21-15
9 AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER
10b KIND OF BUSINESS OR INDUSTRY: ~~DUPONT~~ PLANT HEAVY INDUSTRY
11 BIRTHPLACE (State or foreign country): NORTH CAROLINA
12 CITIZEN OF WHAT COUNTRY? USA.

13 FATHER'S NAME: HARRISON WADKINS
14 MOTHER'S MAIDEN NAME: VICTORIA GAMBLE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): US NAVY WWII
16. SOCIAL SECURITY NO: 240-16-2604
17 INFORMANT: BUDDY R WADKINS — Address: CHESAPEAKE CITY MD

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): GUNSHOT WOUND OF HEAD — INTERVAL BETWEEN ONSET AND DEATH: UNK
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1164

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): SHOT HIMSELF IN A RAGE BLOWING OFF TOP OF HEAD
20c TIME OF INJURY Month Day Year Hour am pm: 7TH 10/7 1967
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): AT HOME
20f (City or town) (County) (State): ELKTON RD#2 CECIL MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Henry V. Davis MD
EXAMINER'S NAME (Type): HENRY V. DAVIS MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (City or town) (County) (State): CHESTER MD
22. DATE SIGNED: 10/7/67

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 10-11-67
23c NAME OF CEMETERY OR CREMATORY: UNION METHODIST
23d LOCATION (City or Town) (County) (State): N. WILKESBORO N.C.

24 FUNERAL DIRECTOR: Robert Foard — ADDRESS: PIPPIN FUNERAL HOME ELKTON, MD.
25a RECEIVING REGISTRAR DATE: OCT 10 1967
25b REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15ME (5)
6M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13777

CERTIFICATE OF DEATH

17904

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   d. STREET ADDRESS: Blue Ball Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Infant — Middle: Gary — Last: Wayne Whitt

4. DATE OF DEATH: Month: Oct. — Day: 28, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 27, 1967

9. AGE (In years last birthday): — yrs
   IF UNDER 1 YEAR: Months: — Days: 1
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arvil Blankenship

14. MOTHER'S MAIDEN NAME: Alma Whitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Alma Whitt, Elkton, Md.
    Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Anoxia — INTERVAL BETWEEN ONSET AND DEATH:
    DUE TO
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
    (b): Cardio - Respiratory Failure — Few hrs.
    DUE TO
    (c): Immaturity — 1 Day

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/27, 1967, to 10/28, 1967 that (I) (we) last saw the deceased alive on 10/27 1967, and that death occurred at 5:10 A M, from causes and on the date stated above

22a. SIGNATURE: Rolando A. Najera M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10/30/67

22c. PHYSICIAN'S NAME (Type): Rolando A. Najera

22d. ADDRESS: 105 E. Main St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/29/67

23c. NAME OF CEMETERY OR CREMATORY: Elkton, Cemetery

23d. LOCATION (City or Town) (County) (State): Elkton, Md.

24. FUNERAL DIRECTOR: Ralph E. Hicks — ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: NOV 27 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13773

CERTIFICATE OF DEATH

13781

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: 112 Alice Ann Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle A. — Last WHITTINGTON

4. DATE OF DEATH: Month October — Day 3 — Year 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-1-09

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bus driver

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Bel Air, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Whittington

14. MOTHER'S MAIDEN NAME: Eloise Ruff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 215-03-3234

17. INFORMANT — Address: VA Hospital records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial insufficiency — INTERVAL BETWEEN ONSET AND DEATH: sudden
4200
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic heart disease
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary emphysema, severe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from Sept. 17, 1962, to Oct. 4, 1967, [illegible] and that death occurred at 1:45 a.m. p.m., from causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10-4-67

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D.

22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct. 9 1967

23c. NAME OF CEMETERY OR CREMATORY: Balto. Nat. Cmtry

23d. LOCATION (City or Town) (County) (State): Baltimore, Md

24. FUNERAL DIRECTOR — ADDRESS: Bullock Funeral Home, Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE: OCT 10 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13779 Item #8 Film #G393 10/17/67 ph

CERTIFICATE OF DEATH

13782

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton c. LENGTH OF STAY IN 1b: 10 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First JESSE Middle L. Last YOUNG	4. DATE OF DEATH: Month Oct. Day 10, Year 1967
5. SEX: Male	6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	8. DATE OF BIRTH: Dec. 17, 1896 (1897)
9. AGE (In years last birthday): 70 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Painter	10b. KIND OF BUSINESS OR INDUSTRY: Home Bldg.
11. BIRTHPLACE (County & State, or foreign country): Bloxom Va.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown	14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 221-09-4885
17. INFORMANT: Agnes F. Moore	Address: Box 24 R.D. 1 Arnold, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Left Cerebral Thrombosis	12 days
DUE TO (b)	Cerebral Atherosclerosis	1 yr.
DUE TO (c)	—	—

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I **certify** that (I) (this hospital) attended the deceased from 9/30, 1967, to 10/10, 1967, that (I) (we) last saw the deceased alive on 10/10 1967, and that death occurred at 5:16 P.M., from causes and on the date stated above.

22a. SIGNATURE: Klaus H. Huebner	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 10/10/67	
22c. PHYSICIAN'S NAME (Type): KLAUS H. HUEBNER	22d. ADDRESS: 106 E. CECIL AVE NORTH EAST Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 10-13-67	23c. NAME OF CEMETERY OR CREMATORY: Liberty Cemetery	23d. LOCATION (City or Town): Parksley	(County): Accomac (State): Va.
24. FUNERAL DIRECTOR: Grant Funeral Home	ADDRESS: Box 22 North East, Md.	25a. REC'D BY REGISTRAR DATE: OCT 13 1967	25b. REGISTRAR'S SIGNATURE: Charles Judge	